DISCUSSION OF PUBLIC-PRIVATE PARTNERSHIP: ITS INFLUENCE UPON OFFICIAL AND NONOFFICAL HEALTH AGENCIES*

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A SPEAKER at this conference is hard pressed not to underscore the major problems in health care or to extol the virtues and the necessity for partnership between government and nongovernmental interests. It appears, however, that this is an audience which is somewhat sympathetic to revolutionary concepts and, if *change* meets those standards, I am with you. If violence is the hallmark of revolution, then perhaps we are at odds.

I believe that those of us in professional roles have a responsibility to test carefully this concept of partnership. We must ask what new benefits will accrue in a partnership between public and private enterprise. What if losses are sustained in this arrangement? It takes no special intellect to detail problems relative to the health field. It takes no unusual insight to design a sound system of health care, and it may take only limited understanding to know what needs to be done. *Doing* it takes inordinate strength, tolerance for stress, and remarkable maturity. My responsibility in this program is to discuss planning—health planning in particular—its progress and activity in our country, and where I think its future will take us. In these remarks, I shall touch on some of the comments that Bernard Bucove has already presented.

It seems that comprehensive health planning, as proposed in the law of 1966 and subsequent amendments, has exposed and provided release for the anxieties and animosities which have been smoldering in the minds and breasts of many health professionals. Physicians, hospital administrators, health officers, and government leaders have for many years been frustrated by the forces and counterforces in the broad field

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of health service. The battleground created by Public Law 89-749 and its administration is nationwide. Major conflicts have occurred and are still occurring, and they are not limited to the metropolitan areas.

It is my observation that some of the wounds that have been opened here in New York City and elsewhere may never be healed as respects the relations among voluntary and official agencies. It may take many years for some of the strains to heal.

Dr. Bucove, if I heard him correctly, indicated that the ambiguity of the law and its administration has brought about these difficulties, and that if the government responsibility as assigned to the state level would be applied in the same fashion locally, then areawide planning could proceed without difficulty. I gather from Dr. Bucove's remarks that assigning to government at an areawide level the responsibility for organizing and administering comprehensive health planning would make things simpler. While this would certainly clarify the question of designation of the *B* agency responsible for areawide planning, it would not be consistent with the law as I understand it. It would not simplify the development of planning, and it would not advance the art and science of planning. Further, it would not assure the effective services which are to be the outcome of any planning program. I think we need to examine the inherent and special qualities found in private enterprise as well as in governmental agencies as we approach planning with new concepts of joint effort.

One of the problems that we face in trying to bring together some kind of harmony between private and public interests has been that each has attempted with vigor to describe the role and responsibility of the other. Each sector has indicated where the limits of the other's functions should lie. Each has refrained from describing where it can produce most effectively and where points of contact might be established.

Some significant roles were played by early voluntary health agencies. Some of the categorical disease-oriented health agencies were extremely influential in the establishment of special grants and authorities to do research in fields such as heart, cancer, and tuberculosis. We found that groups of parents concerned with handicapping conditions of a specialized nature were tremendous forces for developing crippled children's services in such areas as pediatric cardiology, open-heart surgery, correction of cleft palate, and a wide range of orthopedic difficulties.

It is known that commercial and voluntary groups have initiated insurance and prepayment mechanisms and, in some areas, direct service programs that certainly were far in advance of developments in government. What has government done, then, in its efforts to be creative? It has promoted programs that focus on the aging, on poverty-stricken groups, and on behavior problems of children. Many of these programs are wrapped up in such monumental, comprehensive, and promising projects as the one for model cities.

These programs usually have reflected the governmental attitude that existing resources are inadequate to the new tasks. These programs reflect a good deal more also. They suggest that there is a lack of interest on the part of existing groups in the community, government or voluntary, to undertake change and the advancement of ideas on new programs. This question of confidence in established community institutions, this question of respect, is one that pervades many of our problems, at least in planning, and it is one of the reasons why planning is not doing better after two and one-half years.

We need at this point to define the inherent qualities of voluntarism. The private sector cannot be defined solely on the basis of an alternative to government or as a means of preventing government inroads into the private sector of health. Voluntarism must be advanced because of its unique values and important inherent qualities. We used to be able to describe them in terms of leadership, creativity, research, and demonstration. We must be able to suggest that voluntarism could serve as both a compatible and supporting agency to government and, from time to time, as its most staunch critic.

In the last few years those of us in the voluntary sector have found ourselves more in the roles of critics. We have tried to catch up with some of the innovations of the federal government but, in many respects, the most important signs of leadership have come from the federal establishment.

To date we have failed to define clearly the public interest in health. Take, for example, airlines, television stations, taxicabs, or banks. At the national and state levels, and sometimes at the local level, we have defined the nature of public interest and have moved on to establish the nature of public policies in order to protect that public interest.

At this stage in our social evolution we need to move more deliberately toward establishing the degree of public interest in health affairs.

For example, is the public interested in the health of the individual? Is it concerned about what the individual will do to prevent the onset of heart attacks, or is the public interest more likely to be intense and significant when the individual sustains a heart attack and requires some kind of organized service in order to alleviate the condition?

It is suggested that the question of public interest and the type of public policy it stimulates must be examined by both the private sector and the public sector, from time to time independently but perhaps most effectively in joint fashion.

In the development of Public Law 89-749 and its amendements and in the all-important administrative procedures there has been little or ganized participation by the nonfederal, nongovernmental sector. The lack of participation by other than federal officials does not satisfy, by any manner, shape, or means the objective of establishing a partnership in health.

As a representative of the voluntary sector I believe it is not enough to assign to voluntary enterprise a position equal to that of government. Rather, some of our defensive and reactive behavior in relation to government is rather childish. I think we must seek to advance the means and substance of service beyond that proposed in federal programs. We must reestablish the nature and role of voluntary enterprise, which is one of leadership, and we must provide stimulation for government to assume responsibility for programs once they are determined to be truly in the public interest.

I recall an experience not long ago of working with a group of citizens from our Chinese community around the subject of a neighborhood health center. The representatives of the Chinese group were bright and creative people and they came to us with a proposal on which they sought consultation and guidance in program planning. We sat with them and read their description of the origin of Chinese culture in San Francisco, its history, and some of its problems. It was a brilliant piece of work. It would have won favorable response from some of our more literate magazines.

These people understood their community. They were aware of their community problems. They returned a few weeks later after our first contact, and put on my desk a description of a neighborhood health center for Chinatown. In their original proposal, the original outline of the nature of the Chinese community, they described certain character-

istics of health, how the Chinese people saw illness, what they did about illness. There was documentation of how the Chinese culture was frequently at odds with western medicine. When we had an opportunity to read the proposal for meeting the health needs of the community we were uneasy. It did not make sense. It did not seem to fit. Something was out of alignment. They had described the nature of their community but the program for solving some of their health problems were just not compatible with the unique features of their Chinese culture.

At about this time I had occasion to visit the neighborhood health center sponsored by Tufts Medical School, Boston, Mass. After a short while, I was impressed by the similarity between the Columbia Point program and the proposal suggested for meeting the health needs of the Chinese community. In fact, it was the Tufts' program, almost down to the very words.

Upon my return to San Francisco, I inquired about this because I thought it was more than a coincidence; indeed, it proved to be more than a coincidence. The Chinese said, when I asked them about it, that the Columbia Point was a model that they had chosen to follow because "it had been funded. This is a program we are sure will be financed." While there may have been truth to this statement, it was indeed sad that the understanding these people had of their community was being overlooked and subordinated in order to give the federal government a program that it appeared to want and would fund.

I suggest there is something wrong here. Somehow or other, communities feel that they are not to be trusted to innovate and create in a fashion that will help them respond to the unique characteristics of their area. We could all think of examples of this, I am sure. I understand that once a comprehensive health planning project is approved in one community of a state, it is likely to be widely circulated in other parts of the state because it is a winning combination, even though the development of comprehensive health planning in one area might appropriately be quite different from that in another area. We must begin to reestablish our confidence in the ability of responsible community leaders to undertake the development of the mechanisms of planning. Then we must be very careful not to lock them into what *we* think is an ideal model as represented by the community of another region.

May I say a few words about planning at this stage. Many of us have certain judgments based upon experience. It is suggested that plan-

ning is not a substitute of one organization's judgment for another's. Planning should not be seen principally as a means of control, and it will not solve all our health problems, but it can and should be a more rational and a more reasonable way of reaching important decisions on health service. I think planning can best serve if it is promotional and positive, indeed, educational. It can improve our problem-solving abilities if conducted with this approach.

We must define the two major types of planning. Planning at the community or areawide level is different from planning at the institutional level. The first is a means of setting direction, providing coordination, and assisting established agencies to reach desirable goals. The second is an operational responsibility connected with managerial or decision-making functions. Whether the institution is a health department, a heart association, a medical society, or a waste-disposal plant, operational planning should proceed. Any agency that has the responsibility for delivering service day in and day out is the one that is ultimately held accountable and responsible, not the planning agency.

What an operating organization needs most of all from a planning agency is not precise direction, not to be told it is doing too much or too little. It needs, indeed, some help and understanding of how it fits into the constellation of services in the community. It needs help in organizing itself and assistance in doing better planning, in reaching better decisions and in providing better services.

Comprehensive planning is not going well, in my view, partly because it is looked upon as a control mechanism—as a means for centralizing decision making. It is suggested that the steps that are being proposed for hospitals here in New York City—decentralized decision making—are in some part an effort to decentralize planning so that each hospital can enjoy the participation of the persons in the neighborhood it serves and so that those persons can look forward in terms of what kinds of services that institution should provide.

It is necessary, however, to be realistic about controls. It seems to me that regulations do function in relation to banks, and controls exercised by a comptroller of the currency provide for restricted entry into the field. These controls or regulations are accepted by banks, and certainly banks are representative of our capitalistic, free-enterprise system. But I think it is important that we separate the issue of controls from planning and do not attempt to tie the two together in a single agency.

Regulations are really a negative force employed to ensure that the public interest will be satisfied at least to a minimum level, to assure that standards will be met. The fact that we have a comptroller of the currency to restrict entry into banking provides certain minimal characteristics, but it does not move the bank into new services and it does not inspire the bank to undertake new programs. It does not help the bank do a better job as far as the needs of a depositor or borrower go. Planning, I suggest, really needs to take over at this point, and planning must be promotional. It needs to inspire, it needs to enhance the capacity of an organization in the community to fulfil its purpose, and to give the institution some idea of what a higher purpose might be.

If we are to prevent further conflict in the development of comprehensive planning, I think we must reassess the program in its entirety. We are about to lose the participation of hundreds of community leaders across the country. At the same time we are trying to interest new consumer groups.

The federal government has dealt planning a severe blow. It has promised an undeliverable goal and has been guilty of some misguided efforts. For example, the low status of the Office of Comprehensive Planning is some indication of how the federal government looks upon this program. At present the program is little more than a grants-management service, and it should be much more. At this point it does not have the position in the federal establishment which can allow it to influence federal programs and to provide the leadership nationally which I think would be more positive and more stimulating.

I concur with Walter J. McNerney's proposal for a council of advisors, either in relation to planning or in terms of the broader role of health policy. Certainly the question of public interest and public policy in regard to health needs the support of a very high-level continuous body in our country.

Comprehensive health planning really must succeed, but it can improve conditions only if it builds on established community assets. Otherwise we must accept the fruits of revolution. If planning must grow out of previous fruitless attempts, if it must inhibit the natural tendency to create and to improve—if, in short, it operates principally as a force of conservation—I think we shall have failed. We shall have cemented ourselves into the present state of affairs which is not satisfactory to anyone.

This would be unfortunate. Planning, as a representative of private and government interests (with neither predominant) must stimulate, must tolerate change and differences, and it must be prepared to fail from time to time. It must suggest, enhance, revise, and reflect, and it must challenge.

When we work with people we usually do not ridicule self-interest and self-esteem. We consider these qualities as positive personality characteristics and we use them to help any person strengthen and advance his objectives.

It is suggested that when we work with established institutions in our community, voluntary and governmental alike, we must meet them with the same acceptance and respect we employ in our interpersonal relations. If this is the basis for our future association, then I think that comprehensive health planning can exploit the concept of true partnership, and that both the government and the voluntary sector can function effectively.